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This study examined different training programs to include in a comprehensive training program to increase the quality of caring and job satisfaction in Moncrief Army Hospital. Patient complaint data was used to identify problems with quality of care. Various other programs were observed for their applicability. A three phase program was designed to concentrate on three areas: improvement of patient environment, employee environment, and patient awareness training. Keywords:

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A STUDY TO DETERMINE METHODS TO IMPROVE PATIENT AWARENESS AT MONCRIEF ARMY HOSPITAL FORT JACKSON, SOUTH CAROLINA

A Problem Solving Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

By

Major James R. Jacobs, MSC

April 1980

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INTRODUCTION

The interaction of patient and provider in the health care setting is a highly emotional encounter which is sometimes further complicated by factors of personality, setting and lack of control over necessary resources. Acceptance by the public of the concept of health care as a right, coupled with a chronic shortage of primary care physicians, places heavy demands on a system which is unable to absorb the rapid increase in the numbers seeking care. Shortages of physician manpower have led first to a specialization of paraprofessional skills and to lengthening queues at primary entry points into the medical care system. The skill specialization at the paraprofessional level has resulted in a system where the patient must negotiate a series of clinical and administrative intermediaries prior to receiving definitive care. An emotionally loaded situation exists when an anxious patient comes into contact with an administrative or clinical paraprofessional who has no ultimate control over the availability of the physician. There is significant potential for conflict in this situation and if this potential is allowed to go unchecked, hostile attitudes degenerate into patient dissatisfaction and complaints. Ill feelings, generated at this level, often carry through the entire health care episode and are independent of the technical quality of the care rendered.

The emotions and personality of the parties to the health care encounter are the primary factors in establishing the conflict situation, and are the only key to its proper resolution. The patient is concerned, anxious and distracted because of his medical condition, and can be expected to react in unnatural ways to even routine stress. Regardless of the criteria by which

the hospital classifies emergencies or categories of care, the patient feels real pain and considers his complaint of central importance. When others do not respond in a knowledgeable and compassionate manner to this perceived condition, the patient may become hostile and demanding.

Hospital employees, in theory, are expected to separate their actions in dealing with patients from their own personal feelings. This is, of course, a patent impossibility. Each employee brings a full set of attitudes, beliefs and emotions into the workplace, and employees suffer the same personal problems and minor illnesses that their customers do. Employees who fill positions where first contact is made with the patient are pressed from all sides in pursuance of their duties. They are often low in the rank/status structure of the organization and they have no real control over the resources being sought by the patient. At the same time, they must deal with large numbers of demanding patients who, due to their status in assuming the sick role, have been exempted from normal behavioral conventions. The employee is expected to exercise loyalty to the organization by adhering to and enforcing established rules and policies. This gatekeeping function often becomes the primary generator of conflict as the gatekeeper often lacks the expertise or desire to exercise judgement in applying these rules. When individual needs for power and status enter into this equation, the situation can be disastrous to the patient/provider relationship.

Though efforts at consumer education may reduce, somewhat, the stress on the system, only modification of employee attitudes will have any potential for reducing conflict in this situation. Authorities differ as to what the best way to attack this problem might be; however, most agree that this is a multidimensional problem. In order to effectively interact with patients, the employee must develop communication skills, knowledge of the organization, an

awareness of his own feelings, and an appreciation for what the patient is experiencing. In order to reflect a caring attitude, the employee must feel good about himself and the job. Achievement of this kind of job satisfaction comes only when the employee perceives his contribution to the institution as having value, and when the employee is given recognition and afforded the opportunity to grow. Supervisors at all levels must become involved in this process by providing the employee a stake in the organization and providing the knowledge necessary for the employee to perform effectively. Each supervisor must also be aware of the dynamics of the employment situation, and be supportive in buffering the stress of the workplace.

There are any number of prepared programs, designed to foster improved patient awareness and customer relations. However, it is doubtful that any one program or one time effort will be capable of reaching and having a lasting effect on all groups involved. Programs must be tailored to the specific group and be conducted on a continual basis. The use of consultants and guest lecturers are valid techniques but management must not abdicate overall responsibility for design and continuity of programs. Consideration must also be given to the difficulty of true behavior modification. Realistically, the best results will probably come through generating awareness of individual feelings and providing some alternative methods for dealing with situations.

This study will attempt to identify specific target groups for such awareness training and establish some characteristics of each group which might suggest the success of a given type of program. Then, various types of existing programs will be examined in light of their potential for meeting the specific needs identified. In addition certain other alternatives will be examined which may help in minimizing the amount of conflict potential which must be dealt with through training programs.

STATEMENT OF THE PROBLEM

To increase the quality of caring at Moncrief Army Hospital through patient awareness training and increased job satisfaction of personnel involved in initial patient contacts.

RESEARCH METHODOLOGY

Research into case files of patient complaints and direct observation of both face-to-face and telephone conversations, was used to develop a profile of patient complaints. This analysis was used to isolate the source of complaints by location and to identify the primary factor leading to the development of conflict. These factors were broadly grouped into problems resulting from the technical quality of care and those resulting from the quality of caring. The resulting categories were used to define the exact nature of problems in specific areas. Further development of this data was accomplished through direct observation of areas demonstrating high concentrations of complaints. Other patient satisfaction data was used to verify or supplement the findings of the patient complaint data and direct observation.

Each job identified as an initial point of contact with patients was analysed with respect to job description, grade structure and any specific characteristics of the patient population being served in that area. This data was used to correlate the incidence of complaints with any common characteristic of the employee or the type of patient being seen. The incidence of complaints was also compared to various workload factors to

determine the existence of any relationship.

The second component of the study consisted of a thorough analysis of existing programs in patient awareness and customer relations in both federal and non-federal hospitals and other service industries. Each of the programs was evaluated according to the specificity of the target group, the element in the conflict situation to which the program is directed, and the success rate of the program, both initially and over time.

Finally, an attempt was made to integrate the needs of specific employee groups with training modules, to form a comprehensive patient awareness training program.

LIMITATIONS

Patient satisfaction and acceptable levels of patient complaints are both subjective measures. Consumers are better educated and more informed in their decision making than ever before, but they are not qualified to evaluate the technical quality of care. This leaves the assessment of quality to the intangible areas of expressed concern and attitude. Definitions of quality in this area will vary extensively from person to person.

Concentration of sampling on those who file complaints may skew the findings in favor of certain personality types or types of complaint. Studies in this area of consumer satisfaction have shown that only a limited percent of dissatisfied consumers will voice complaints. This action oriented group has certain characteristics which may predict the types of complaints which would be voiced. These voiced complaints may not accurately portray the real nature of dissatisfaction.

It may not be possible to satisfy all patients, given the chronic shortages of manpower. Even the most effective patient awareness program will not

create consumer satisfaction if the patient is unable to see a practitioner within a reasonable period of time. Patients may also continue to be dissatisfied if the patient/provider encounter does not provide the instant cure popularized in the media and advertising.

ASSUMPTIONS

(1) Physician staffing will not improve significantly.

(2) Patient input will not vary significantly

(3) That the number of complaints can be reduced through increased patient awareness.

LITERATURE REVIEW

Increasing numbers of consumers, in all sectors of the economy, are seeking primary health care through hospital outpatient departments and Emergency Rooms. Health Care consumers enter the hospital with expectations which differ radically from those of earlier patient groups. Today, consumers look on quality health care as a right, and consider that first class care is due everyone regardless of social or financial condition.[1] Overselling, through television "Doctor" shows and advertising, of the ability of medicine to perform healing miracles, has generated unrealistic demands on providers of care.[2] The growth of consumerism has led to the feeling, among consumers, that there is a right to pass judgement on providers of care when this instant cure is not forthcoming.[3]

Sick people are unusually sensitive to any stimuli, and the assumption

of the sick role exempts them from many of the conventions of normal behavior. This same role pattern dictates a dependency on the health care provider. Providers often assume that this dependency is limited to the technical aspects of medical care, but the patient perceives this dependence to include the human aspects of caring also. This highly sensitized individual enters a strange environment, apprehensive of the awesome technology and fearful of the experience to come.[4] The patient needs information about his condition and about the process of receiving care, but the flood of directions and instructions is often hopelessly confusing. Though better informed as a consumer, today's patient is still unable to evaluate the technical quality of the care rendered. Therefore, lasting impressions are often based on the caring aspects rather than the technical proficiency of care.[5]

On the other side of this equation is the hospital employee whose advancement is dependent on the proficient operation or manipulation of the technology of medical care. The human side of this transaction receives little attention and is often considered a necessary evil of treating disease.[6] The surroundings and procedures are monotonously routine to the hospital employee and the ever present technology holds no fear for him.[7] Continuous interaction with distraught patients, whether it be in the emergency room or admitting or appointments may, however, cause psychological debilitation and "Burn Out" for the employee. This condition, caused by stress, frustration and lack of job satisfaction, manifests itself in reduced effectiveness and projection of hostility toward customers. Such "Burn Out" may be the cause of much of the inefficient and impersonal treatment provided by service organizations throughout the economy, as employees attempt to insulate themselves from the stress of interpersonal interactions.[8]

The intricate complexity of the hospital organization, with its multitude

of professional, technical and administrative skills, adds to the conflict potential.[9] The patient often becomes the innocent victim of inter-group conflict or of the attempt of one group to supplement its ego needs. If roles are not clearly defined and integrative mechanisms are not in place to foster communication among departments, the patient is often used as a go-between to make a point to departments which are in unknowing violation of some hospital policy. Where status relationships are unclear or where an employee group feels that they are not receiving adequate recognition, abuse of patients may be used to supplement this ego need. Unfair distribution of workload may lead to situations where patient demands are rejected as not being the responsibility of the person or section involved. In these situations, the patient may be unaware of the nature of the inter-group conflict, but the feeling of being caught in the middle may cause negative impressions of the episode.

Interaction of patient and provider in this atmosphere often leads to dissatisfaction and complaints. As would be expected from the foregoing description, most patient complaints center around the human aspects of caring rather than the technical quality of care rendered.[10] In voicing dissatisfaction, patients most frequently note long waits, apparent lack of concern on the part of providers, and confusion regarding the hospital system.[11] For most patients, not knowing why a wait is necessary and how long the waiting period will be, causes more concern than the wait itself.[12]

Both hospital employees and patients bring all of their human emotions into the health care transaction. Because of this, it is often impossible to isolate the real problem which leads to a complaint or to analyse the reaction of a staff member, based strictly on the circumstances of the immediate interaction. It is equally difficult to determine the extent of patient dissatisfaction based solely on voiced complaints. A study conducted by Andreasen and

Best, indicates that only three out of every ten dissatisfied consumers ever bother to voice their dissatisfaction with medical or dental services.[13] An earlier study by Warland, Herrmann and Willits, indicates that persons who voice complaints exhibit certain common traits, and that the types of concerns expressed by this group may not accurately portray the true nature of overall dissatisfaction.[14]

Most survey instruments which attempt to measure satisfaction/dissatisfaction are quite subjective in that they are reliant on the patient's perception of quality and satisfaction.[15] The reliability of such surveys is further exacerbated by a type of "Halo" effect which cause after the fact evaluations to be a reflection of the patient's current state of wellness. That is, if the patient's physical problem has been resolved, the entire encounter is looked on in a favorable light. Patients may also couch replies in positive terms out of fear that negative remarks may jeopardize the quality of future care.[16] Some analysts report that comments added by respondents in open spaces provided on many patient surveys prove of more value in identifying problems than do the more structured questions. They note that persons who have strong positive or negative feelings about a service are willing to go to the extra trouble to bring the item to the attention of the surveyor.

Approximately twenty-two percent of the nation's hospitals now employ a Patient Representative to help identify and resolve problems encountered by patients.[17] The degree of involvement of the Patient Representative in the institutional decision making process varies from one hospital to another, but, as a minimum, the Patient Representative must be an individual who is willing to listen objectively to patient concerns and capable of acting to remedy the problems identified.[18] This function implies extensive knowledge of the organization and its procedures, ready access to hospital staff, and authority to follow up on corrective actions. To be effective in the long run, the Patient

Representative must have input into the decision making apparatus of the institution so that lasting solutions can be implemented.

One approach to the problem identification and resolution process was the establishment of a Patient Care Committee. This committee, with representation from administration, major departments and the Patient Representative, reviews problem trends in non-technical areas of care, developed by the Patient Representative from patient survey and complaint data. The committee makes recommendations for corrective action and follows up at subsequent meetings to insure compliance. The use of the committee provides the Patient Representative with input into the decision making process and lends top management support to the Patient Representative Program.[19]

Improvement of patient satisfaction, though difficult to achieve, is not impossible, given commitment on the part of the entire staff. Little will be gained by training clerical personnel to be more aware of patient needs if physicians do not continue this behavior during treatment and followup?[20] These attitudes must be internalized at the working level but must be bolstered by top management recognition and support.

Even when problem areas are identified, no single "Canned" program can be relied on to meet the needs of all groups in the institution. Though consultants and guest lecturers can be valuable tools in training programs, the hospital's management must retain the overall responsibility for design and maintenance of the staff development effort.[21] Many consultants attempt single intervention changes or attempt to apply a universal strategy regardless of the situation. Other consultants attempt the use of intervention strategies for which they are inadequately prepared, leading to potentially dangerous emotional situations.[22] Management abdication of the development function may jeopardize any long term improvement in the system operation, as the quick

solutions promised by many outside consultants can prove to be more vision than fact.[23]

A more rational approach to change intervention is the development of a process which will isolate specific problems and identify specific employee groups for which training programs are needed. This mechanism should include employees themselves in the identification of problems and the design of programs.[24] Thus, simple department level seminars, designed to give the employee information to deal more effectively with immediate problems, will have the most beneficial effect. In order to set the tone for desired behavior, this training should begin during the employee's orientation and continue on a recurring basis throughout the employee's period of employment.[25]

Supervisory training is an integral part of improved patient satisfaction, as the quality of supervision impacts directly on the attitudes of employees toward the patient.[26] A person who is upset with his supervisor is less likely to treat patients with courtesy and kindness. More recent entrants into the job market have new expectations regarding work. They want work which has value to them and to the larger society; they expect upward mobility and they want a say in the structure of the job. Older leaders, with more authoritarian leadership styles, find dealing with these new values very difficult and lack tools to motivate these workers.[27] Today's supervisor must know more about people in order to manage effectively.[28] They must develope communication and interpersonal skills, they must be knowledgeable regarding the work being performed and they must be aware of the stresses of the work situation. For first level supervisors, this training is most effective when theory is applied to actual situations in the workplace.[29]

Because long term behavior change is so difficult,[30] and because the effects of job related stress are so damaging to both performance and health,[31]

it is in the best interest of the institution to minimize the amount of potential conflict which must be dealt with through behavior modification. Some reduction of conflict potential can be obtained by providing patient information and by presenting an environment which transmits an impression of concern for the patient. Information concerning available services and the procedure for obtaining these services should be made available to all potential patients. Not only will this reduce the anxiety experienced by patients, but will reduce the number of routine inquiries processed by appointments operators and other staff members. The image expressed by the environment of the institution can have a significant impact on patient attitudes. The presentation of clear directions for the location of services and amenities expresses a concerned attitude, as does the thoughtful arrangement of waiting and reception areas. When ease of movement through the facility and pleasant surroundings relax the patient, there is less conflict potential to be dealt with by staff personnel.[32]

DISCUSSION

In order to achieve the development of a program for training in patient awareness, it was imperative, first, to identify those factors in the present system which impacted negatively on the quality of caring. Initial research therefore, was directed toward defining the types of problems which patients perceived as effecting the quality of care rendered. Once the identity and locus of these problems could be established, a direction for training, if indicated, could be ascertained. A great deal of existing data, in the form of patient complaint files, outpatient surveys and previous management studies were available for this analysis. Patient complaint data covering a nine month period from May 1979 through January 1980, were used to define problem areas and highlight any obvious trends. The other data sources were used to supplement and verify impressions developed from the patient complaint data. Each of the data sets contained inherent bias which could distort results, but the combination provided an accurate enough portrayal of the environment to allow the concentration of direct observation in those areas demonstrating higher than normal problem potential.

The work of several researchers into the area of consumer satisfaction and voicing rates indicated that total reliance on patient complaint data would not only exclude a significant proportion of dissatisfied patients, but might also misrepresent the actual problems effecting care. Alan Andreasen and Arthur Best, in their study of consumer satisfaction, indicate that only 32.7 percent of those individuals having problems with medical or dental services voiced their dissatisfaction with those services.[33] Warland, Herrmann and

Willits, in an earlier study, indicate that persons who actively voice complaints have certain common characteristics which may cause some types of problems to be over represented among voiced complaints.[34] Applying these findings to patient complaint data would indicate that many complaints are never voiced, others never enter the official complaints system of the hospital, and those that are entered may not be representative of overall dissatisfaction. Findings of the September 1979 Outpatient Survey, conducted at this hospital, add credence to this potential loss of data. In that survey, it was noted that 16.3 percent of the respondents felt that there was no source of contact within the facility where complaints or suggestions could be freely discussed. This may indicate a failure to properly publicize this service, which could result in problems being addressed to and resolved by other sections. The significance of this percentage is increased when cognizance is taken that negative responses to this question were concentrated in the Troop Medical Clinic and the Outpatient Clinic: the primary entry point for most patients.

The usefulness of outpatient survey data is limited by the parameters of the analysis and by the process used in obtaining responses. By limiting the analysis to outpatient activities, problems of interaction or integration among diverse hospital activities are obscured. Also, the process of administering the questionnaire while the patient waits for his or her appointment limits the patient's observations to the early elements of the current episode, or to reflections on previous visits. This practice can add unwarranted importance to factors such as availability of parking and the conduct of clerical and appointments personnel, or can lead to the recollection of the worst case among several previous enccunters. Individuals may also be hesitant to make totally honest answers to questions on patient satisfaction surveys

because of concern that negative remarks might jeopardize future care. The bias against negative remarks is particularly true of Basic Trainees who are highly intimidated by the newness of the military system.

Aggregation of the Data

During the period selected for analysis, 557 individuals filed inquiries with the hospital's Patient Representative office. Initial aggregation of this data was accomplished by assigning each inquiry to one of twenty-four general headings. (Table 1, pages 16-17, provides a complete analysis of this data, by month). The total number of inquiries, thus classified, exceeded the number of individual inquiries as some individuals expressed more than one concern on the complaint form. Based on interpretation of the types of data contained in each of the general headings, further definitive grouping was made under the three categories of: Informational Inquiries, Assistance Requests and Complaints. Informational Inquiries made up 12.9 percent of the total and included requests for information, suggestions and those inquiries having insufficient data for classification. Assistance Requests constituted 35 percent of the total. The preponderance of these inquiries were requests for assistance in interfacing with or entering the hospital's health care delivery system. Sixty percent of the Assistance Requests were for assistance in getting appointments. Two other significant groups were those seeking assistance in obtaining medical discharges or in rebutting Medical Evaluation Boards.

Though Informational Inquiries and Assistance Requests were eliminated from further analysis as being unrelated to resolvable patient dissatisfaction, they may illustrate some underlying problems. The numbers of individuals requesting assistance in getting appointments may indicate a lack of information regarding system access, poor communications between patients and

TABLE 1

INQUIRIES FILED WITH THE PATIENT REPRESENTATIVE

TYPE OF PROBLEM	NUMBER OF OCCURRENCES, BY MONTH										
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	TOTAL	PERCENT
INFORMATION INQUIRIES											
Information Request	2	8	8	10	3	1	6	6	6	50	9
Question on Profile	1	1	1	1	0	0	1	1	0	6	1
Insufficient Data for Classification	4	0	2	0	3	3	2	0	2	16	2.7
ASSISTANCE REQUESTS											
Patient Needs Appointment	13	19	11	16	20	16	9	9	12	125	21
Wants Out of the Service (Medical)	2	4	6	1	5	4	4	1	4	31	5
Wants To Stay In (Being Boarded)	2	0	3	2	3	3	1	1	3	18	3
Wants Entry In Record Changed	1	1	1	0	0	0	0	0	2	5	1
Needs Record for Civilian Physician	2	2	2	2	0	2	0	0	2	12	2
Needs Statement for Insurance	1	2	0	4	0	1	0	0	0	8	1
CHAMPUS Request (NAS or Information)	1	5	0	2	0	1	0	1	0	10	2

TABLE 1 (CONT)

TYPE OF PROBLEM	NUMBER OF OCCURRENCES, BY MONTH										
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	TOTAL	PERCENT
COMPLAINTS											
Quailty of Care	8	14	13	16	10	17	10	4	17	109	18
Misinformation	4	2	0	2	5	8	1	2	6	30	5
Run Around	3	3	0	1	1	1	1	1	2	13	2
Long Wait	6	6	4	5	6	6	9	0	3	45	8
Staff Member Rude	5	7	3	8	3	4	3	2	5	40	7
Lost Record	0	3	2	4	3	0	3	0	1	16	3
Objects To Policy	4	1	3	6	5	0	4	4	1	28	5
Objects To Triage	0	0	0	1	2	2	1	1	0	7	1
Inappropriate Conduct	0	0	1	1	0	2	0	0	1	5	1
Unsafe Act	0	0	1	0	0	0	0	0	0	1	.2
Food Service	1	0	0	1	0	0	0	0	0	2	.3
Parking	0	0	0	0	0	0	1	0	0	1	.2
Complaint Against Another Agency	0	1	1	1	0	0	0	0	0	3	.5
TOTAL	61	79	62	84	69	71	56	33	67	582	

staff, or the lack of sufficient resources to meet the demand for appointments. Though narrative detail is lacking on many of these inquiries, it appears that limited provider resources cause most of these inquiries, with the requirement for more immediate care than normal procedures will provide as the second most common. It appears, also, that some inquiries classified under these two categories resulted from the inability or unwillingness of other staff members to provide the required assistance. This is inferred in some of the narratives but lack of explicit data prevents a determination of the frequency of this type of problem.

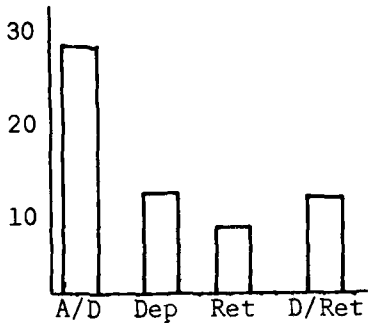
The remaining 51.2 percent of the inquiries were actual complaints. These inquiries were classified strictly according to the perception expressed by the person making the complaint. No cognizance was taken, initially, of the legitimacy of each complaint, as patient perception was an integral part of the problem under study. Later analysis attempted a differentiation between valid and invalid complaints so that technical problems could be distinguished from quality of caring problems.

The largest subgroup classification of the complaint category was identified as Quality of Care. This group included any complaint which referred to the technical quality of the care rendered. Also included in this group were complaints where the patient felt that treatment had not improved their condition and where the patient stated that clinical personnel did not exhibit concern for their problem. Table 2, illustrates that 47 percent of Quality of Care complaints were registered by Active Duty Personnel, with Basic Trainees lodging 48 percent of the Active Duty Complaints. Table 2, also shows the distribution of Quality of Care complaints by functional area and underlines the heavy concentration of Quality of Care complaints in the clinic and Emergency Room areas.

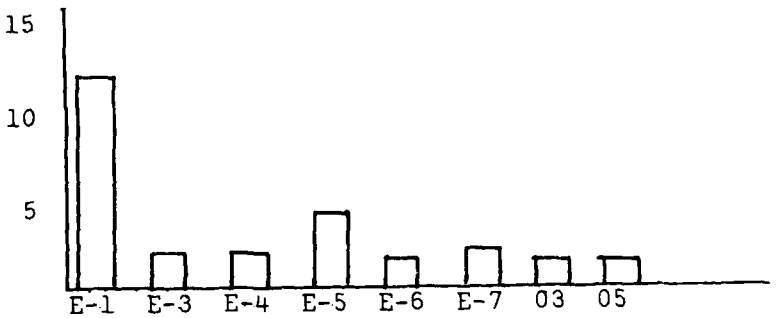
TABLE 2

QUALITY OF CARE COMPLAINTS

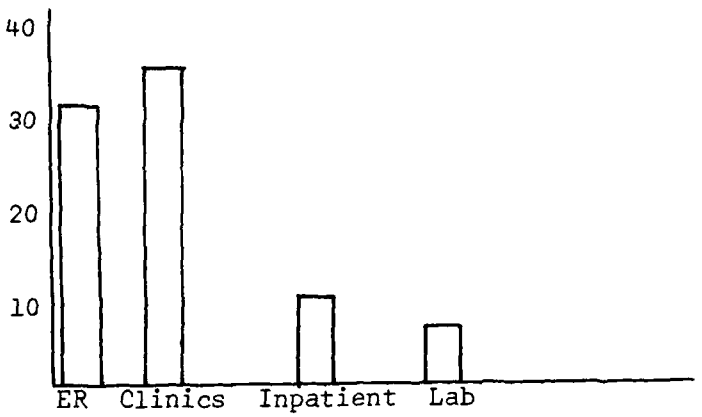
Rank/Status of Person Lodging the Complaint



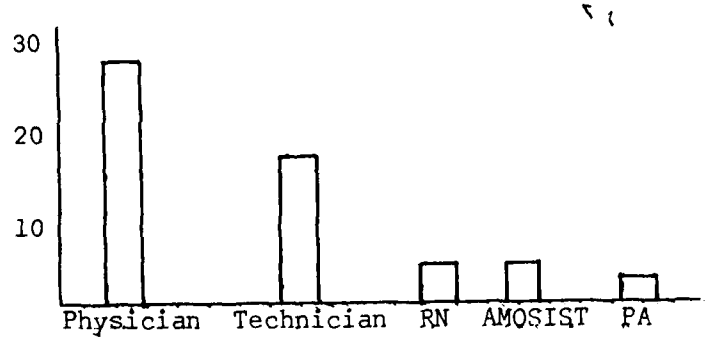
Rank of Active Duty Lodging the Complaint



Location of Complaints by Functional Area



Type of Provider Identified in the Complaint



Analysis of the legitimacy of Quality of Care complaints was accomplished using both the data contained in the narrative summary of the complaint and the investigatory results compiled by the Patient Representative. The complaint was considered valid if the care rendered was not technically correct or was in violation of established hospital policy. The complaint was classified as questionable if there was doubt as to the efficacy of the treatment regimen or if there was insufficient data to determine what treatment was actually rendered. The complaint was considered invalid if the care rendered was technically correct or in compliance with established hospital policy. As shown in Table 3, only 15.6 percent of the Quality of Care complaints were considered as being valid. The Emergency Room had the highest percentage of valid Quality of Care complaints. Physicians, as a group, were identified most frequently as the subject of Quality of Care Complaints.

TABLE 3

ASSESSMENT OF VALIDITY IN QUALITY OF CARE COMPLAINTS

Classification of Quality of Care Complaints by Area

	ER	CLINICS	INPATIENT	LAB	NUC. MED	UNSPEC AREA
Valid	11	5	1	0	0	0
Questionable	13	21	6	0	0	30
Invalid	9	5	4	3	1	0

Percent Validity of Quality of Care Complaints

	ER	CLINICS	INPATIENT	LAB	NUC. MED	UNSPEC AREA
Valid	33	16	9	0	0	0
Questionable	40	68	55	0	0	100
Invalid	27	16	36	100	100	0

The second most prevalent type of complaint expressed was dissatisfaction over the length of waiting time. Fifty percent of these complaints were lodged against the Emergency Room, while 43 percent were lodged against clinic areas. Again, no attempt was made to determine the validity of the complaint. If the patient perceived the wait to be too long, it was classified as such. There was no definite trend in the rank/status of individuals making length of wait complaints. Six of the forty-four complaints in this area concerned dissatisfaction over the long wait for appointments; while the remainder involved the time spent waiting in the clinic. Twenty percent of those who complained of long waits included at least one other area of dissatisfaction on their complaint.

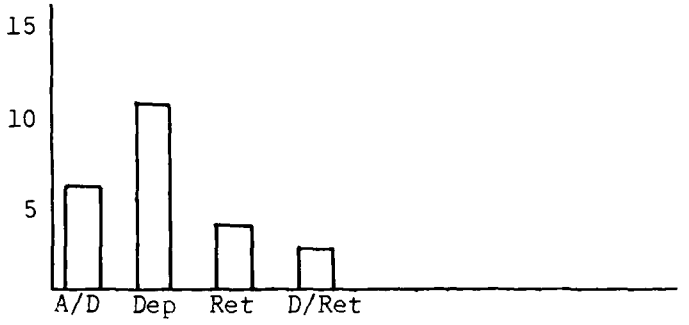
The next major sub-group of complaints were those alleging staff rudeness. Complaints of rudeness were concentrated in clinic areas (with 27% of the total), Emergency Room (with 24% of the total), and Central Appointments (with 22% of the total). In half of all rudeness complaints, technicians were identified as the offender, with appointments operators constituting the second largest group. Twenty two percent of rudeness complaints resulted from telephone transactions. Sixteen percent of those listing rudeness as a problem also listed one or more other items of dissatisfaction in their complaint.

Ten percent of complaints resulted from misleading information provided to patients. Most of these complaints stemmed from misunderstanding by patients regarding the date or time of appointments made through Central Appointments, or possible incorrect posting of appointment information by Central Appointments personnel. From the available data, it was not possible to determine which of these two was the predominant cause of this type of problem.

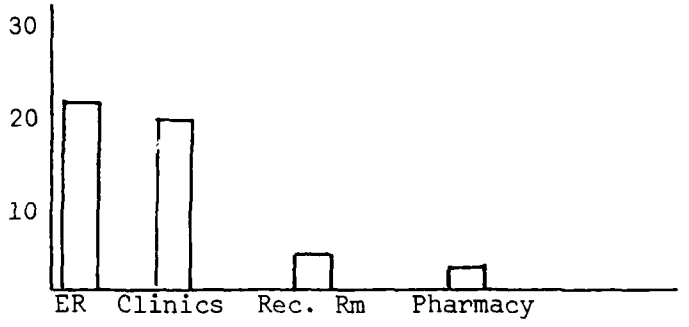
TABLE 4

COMPLAINTS OF LONG WAIT

Rank/Status of Person Lodging the Complaint



Location of Complaint by Functional Area



Long Wait In Clinics, By Clinic

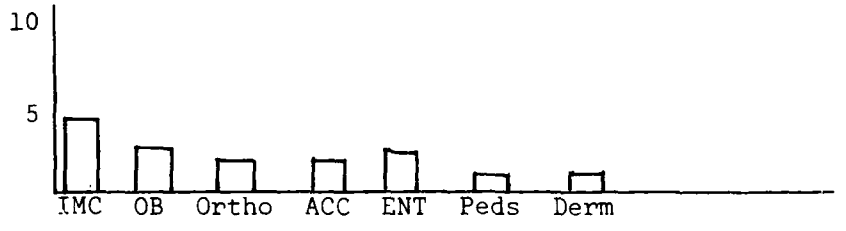
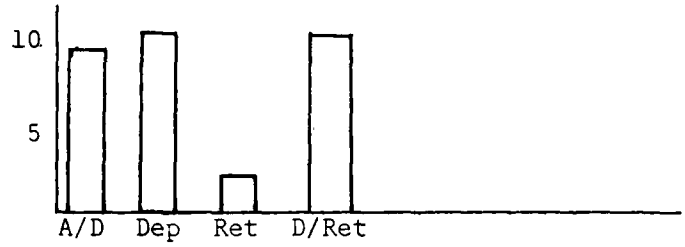


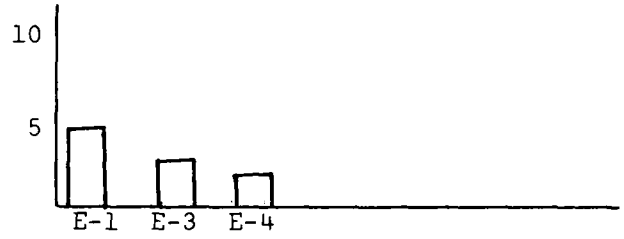
TABLE 5

COMPLAINTS OF STAFF RUDENESS

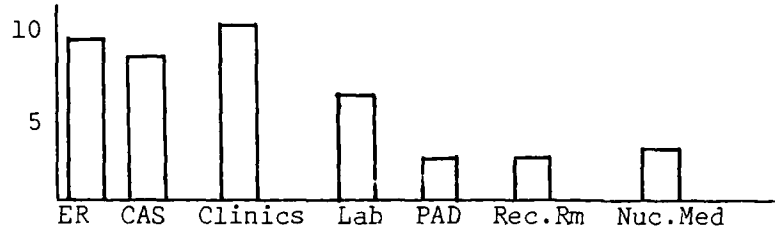
Rank/Status of Person Lodging the Complaint



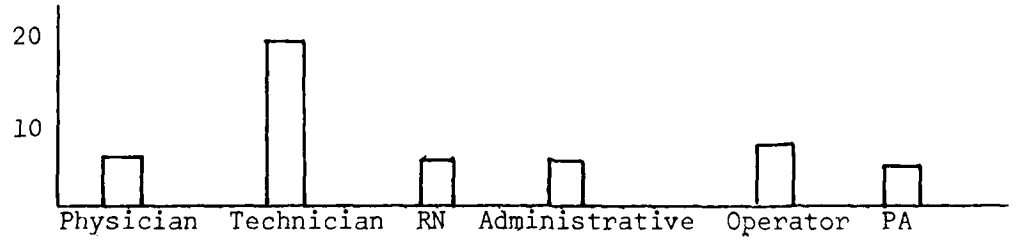
Rank of Active Duty Lodging Complaints



Location of Complaints by Functional Area



Type of Provider Identified In the Complaint



Patients Complaining of having been given the "Run Around" could be classified as a subgroup of misinformation complaints, but are differentiated from them in that Run Arounds involved one or more relocations of the patient prior to the delivery of definitive care. Many of these complaints resulted from lack of familiarity with the system, while others resulted from interdepartmental conflicts. The former type of complaint comes from patients who resent having to go through the examination and referral process on entering the health care system. The latter type of complaint results when a patient is needlessly directed from one location to another due to lack of familiarity, on the part of the staff, of hospital procedure; or because of the unwillingness of the clinic to provide a service.

Concerns over hospital policies made up nine percent of the complaints. The area most commonly noted in this type of complaint was the Pharmacy. This grouping was, however, a statistical artifact in that all of the complaints against the Pharmacy resulted from an end of year restriction on over the counter drugs and prescription refills. Clinics, with 28 percent of the total, and inpatient areas, with 22 percent of the total, represented the next most common areas for policy conflicts.

As a subset of policy complaints, individuals expressing concern over Triage were analysed separately. Only 19 percent of those complaining about Triage were concerned over the treatment rendered. Most of the other complaints indicated a lack of understanding regarding the function of Triage and resistance, on the part of the patient, to undergo the screening process or comply with the screener's recommendations.

TABLE 6

ANALYSIS OF COMPLAINTS BY AREA AND TYPE

TYPE OF COMPLAINT	AREA AND FREQUENCY OF OCCURRENCE									
	ER	CLINICS	INPATIENT	LAB	PHARMACY	NUC. MED	CAS	PAD	REC RM	TOTAL
Quality of care	31	34	10	3	0	1	0	0	0	79
Length of Wait	22	19	0	0	1	0	0	0	2	44
Rudeness	9	10	0	6	0	2	8	1	1	37
Run Around	1	10	0	0	0	0	0	0	0	11
Misinformation	0	0	0	0	0	0	28	0	0	28
Policy	1	5	4	1	6	0	0	0	1	18
Sequence of Patients	1	2	0	1	0	0	0	0	0	4
Food Service	0	0	2	0	0	0	0	0	0	2
TOTAL	65	80	16	11	7	3	36	1	4	223

TABLE 6 (CONT)

Percent of Each Area's Complaints Represented By Type of Complaint

	ER	CLINICS	INPATIENT	LAB	PHARMACY	NUC. MED	CAS	PAD	REC	TOTAL
Quality of care	46	42	62	27	0	33	0	0	0	
Length of Wait	34	24	0	0	14	0	0	0	50	
Rudeness	14	13	0	55	0	67	22	100	25	
Run Around	2	13	0	0	0	0	0	0	0	
Misinformation	0	0	0	0	0	0	78	0	0	
Policy	2	6	25	9	86	0	0	0	25	
Sequence of Patients	2	2	0	9	0	0	0	0	0	
Food Service	0	0	13	0	0	0	0	0	0	

TABLE 6 (CONT)

Percent of Type of Complaint Found In Each Area

	Quality of Care	Length of Wait	Rudeness	Run Around	Sequence	Policy	Food Svc	Misinformation
ER	39	50	34	9	25	5	0	0
Clinics	43	43	27	91	50	28	0	0
Inpatient	13	2	0	0	0	22	100	0
Lab	4	0	16	0	25	5	0	0
Pharmacy	0	0	0	0	0	33	0	0
Nuc Med	1	0	5	0	0	0	0	0
CAS	0	0	22	0	0	0	0	100
PAD	0	0	3	0	0	0	0	0
Rec Rm	0	5	3	0	0	5	0	0

Analysis of Patient Complaint Data

The two largest individual groups of patient inquiries observed were requests for appointments and concern over the technical quality of care. Combined, these two made up thirty-nine percent of the total inquiries. Neither of these is directly concerned with the types of patient satisfaction which could be improved through staff training as the former results from resource constraints and the latter concerns the patient's perception of hands on care delivered by various categories of providers. There seems to be an underlying trend to many of these complaints, however, that patients lack information about the system and the care being rendered, and that staff members may be failing to communicate this information. Also, the long waits and anxiety over the quality of care increase the conflict potential when the patient comes into contact with a receptionist or appointment clerk who has no control over the provider resource.

The number of multiple complaints filed in association with staff rudeness and long waits indicates that patients who become upset by the length of wait or staff rudeness may be more prone to react poorly to other aspects of care. As illustrated by the data, this impression may carry through to other areas of the hospital and may set the tone for the entire hospital stay.

Analysis of the patient complaint data does focus a concentration of complaints in the Emergency Room, Central Appointments and certain of the clinic areas. In these areas, staff rudeness, long waits, and quality of care predominate.

Comparison of Outpatient Survey Data With Patient Complaints

As could be expected, given the inherent bias of the outpatient survey,

trends noted on the September 1979 survey gave greater emphasis to the early events of the health care episode. Facilities such as parking, rest rooms, waiting areas and the outpatient records room, received a much higher percentage of negative comments than in the patient complaint data. This data did tend to confirm many of the assumptions made during analysis of patient complaint data. The outpatient data showed a high degree of dissatisfaction with directions for locating hospital services and with the amount of information provided by the staff. Also, the high percentage of respondents who were unaware of any means of voicing complaints, reinforces the belief that many complaints may go unreported and unresolved.

Direct Observation

Direct observation of activities in the Emergency Room, Central Appointments and the Outpatient Clinic were conducted in order to verify conclusions derived from patient complaint data and to further define the environment.

The hospital Emergency Room suffers from structural and organizational deficiencies which tend to degrade the quality of caring in that area. The waiting area is extremely small, with seating for only sixteen people, in rather close quarters. A television was recently added to the waiting area, but there is no current reading material for waiting patients. The ambulance entrance opens directly into this lobby; thus, any seriously injured patient must be moved through this crowded lobby. The hospital ambulance section operates out of the Emergency Room and the duty crews occupy a small office adjacent to the reception desk. When not on an ambulance run, these personnel assist in logging patients in and taking vital signs. However, when not otherwise occupied, these personnel are often within sight and hearing of waiting patients who associate them with emergency room staff. Temporary partitions, installed to limit observation of the treatment area from the

waiting room, make movement through this area awkward for persons with limited mobility.

There appeared to be a definite difference in the way that Basic Trainees were handled and addressed. In most cases, trainees were not treated rudely, but directions were offered in an abrupt and less than helpful manner. There was also a noticeable difference in the conduct of staff members when they were aware that they were being observed. During those observation sessions when the time and purpose of the visit was announced to the supervisor, staff members seemed much more conscious of their behavior. However, unannounced visits happened to coincide with heavy patient loads, which may have had an influence on the behavior of staff members. The effect of seeing unoccupied ambulance section personnel in and around the reception desk was noticeable among waiting patients, as was the lack of communication between staff and patient. No one ever advised patients regarding the expected length of wait and when patients inquired regarding their position in the queue. The ambulance section staff denied any knowledge of that sequence. Establishing the order in which patients were to be seen, they said, was the responsibility of the Emergency Room staff. Also, visiting between ambulance section personnel and off duty personnel created congestion and confusion in the reception area.

Observation in the Triage and the AMOSIST clinic demonstrated a well run operation. The staff were courteous, well informed concerning their own mission and were quite knowledgeable regarding the procedures of other clinics. The only problem in this area seemed to be a lack of familiarity, on the part of patients, with the Triage system and the function of the AMOSIST. It was not possible to observe this area without giving notice to the clinic staff regarding the purpose of the visit, and this may have influenced the behavior of the staff. This, however, did not seem to be the case.

Observation in Central Appointments, again, may have been effected by the fact that the presence of the observer was known. During these observational periods, no cases of rude behavior were noted. However, several comments made during telephone conversations were provocative in nature and could have been misconstrued by the caller. Two callers alleged that incorrect information had been given to them by Central Appointments during previous calls. One caller said that he had attempted to get his name on a clinic waiting list and the appointments clerk had told him that no such list existed, when in fact there was a waiting list. The other caller had come to the Internal Medicine Clinic, thinking that she had an appointment through Central Appointments, but she was not on the clinic's appointment list. The operator apologized to the first caller and put him on the clinic waiting list. On the second call, the operator searched all of the Internal Medicine physician's appointment lists for several days on either side of the alleged appointment, and found no listing. A new appointment was arranged for this patient. The operators felt that some patients use this technique to get an appointment by making the staff feel guilty for a supposed oversight. In this case, there was no way of determining whose errors these were.

The equipment in use in Central Appointments does little to reduce the problems experienced in this area. The equipment is largely manual, in that the operator must manually select a caller from holding lines. There is no mechanism for determining the number of lost calls or average length of wait. Thus, the supervisor has little upon which to base efficiency or effectiveness criteria.

The Central Appointments operators are under a great deal of stress due to the inflexibility of the system under which they work. They are given a strict set of guidelines under which patients will be appointed to a given

clinic. They are not trained to make medical judgements and are allowed only minimal discretion in filling appointment openings. Often their credibility is undermined when patients go around them and get earlier appointments due to the ability of the clinic secretary to get a priority appointment based on the physician's knowledge of the patient. The appointment clerks are placed in a further bind when physicians fail to provide appointment schedules on time. The clerk is then placed in the position of being unable to provide appointments to callers, and, thus, subject to abuse for something not under her control.

Analysis of Job Content

As job satisfaction seems to be closely linked with employee performance, aspects of job satisfaction among clerical personnel were examined. In each case, receptionists are rated as GS-4 or GS-3, and are carried as Medical Receptionists or Medical Clerk Typist. All receptionists, with the exception of Central Appointments Operators, report to the clinic NCOIC, who, in turn, reports to the NCOIC of the Clinical Support Division. All of the clinic NCOICs carry clinical MOSs, as does the NCOIC of the Clinical Support Division. This clinical orientation of the first and second level supervisors may lend more of a clinical orientation to the evaluation of the receptionists' jobs. As a result, the primary emphasis among the clinic receptionists is the accomplishment of those functions which, though necessary to the function of the clinic, severely restrict the amount of time available for patient interaction. Often such interaction is limited to the giving of directions. Because the receptionist is stationed at the front desk, the completion of these clerical duties is often interpreted by the patient as lack of concern.

Two areas, Nuclear Medicine and Occupational Therapy, had no receptionist, and were forced to use clinical personnel to perform clerical duties. In

Nuclear Medicine, particularly, this causes conflict between staff and patient, as many times no technician is immediately available to give instructions to arriving patients or to give information or appointments over the telephone. The technicians are also dissatisfied because the performance of clerical duties detracts from the quality of their technical performance.

Promotion opportunities for receptionists, as a group, are very limited, and each of the receptionists was aware of this limitation. No staff development courses are made available to this group by the hospital, and nothing beyond the Basic Supervisor's Course, taught through the Civilian Personnel Office, is available to first line supervisors.

Though fluctuations in workload were considered as having a possible impact on job satisfaction and complaint levels, analysis showed this not to be the case. The number of complaints per month and the number of complaints in any given category were fairly consistent over the period and correlated well with any minor fluctuations in population supported, clinic visits and staffing trends.

Analysis of Information Systems

As the need for information seemed to be a common concern among many patients, an analysis of hospital information systems was included to determine any possible impacts of faulty information on patient attitudes. This analysis included directional and informational signs, published patient information and the hospital information service.

The hospital publishes an outpatient information booklet which, though well written, may be too detailed for the convenient use of the beneficiary population. Potential patients must refer to several pages in the booklet to become fully informed about a given service. Much of the available data is subject to change, thus requiring frequent updating if the material is to

be kept current. No effort has been made to field check this publication to determine its utility to the patient population.

The information system within the hospital is scanty. The information desk is actually the admitting desk and the person on duty there is often occupied admitting patients. There is also no guarantee that the person on duty will be familiar with all policies, procedures and the location of all services.

Signs within the hospital are excessive, yet do not provide clear directions to all services. Many of the informational signs are excessively wordy, thus discouraging a complete reading by any patient. Other signs are temporary, hand written, and made from paper. The resulting clutter causes confusion and obscures the relevant information.

Analysis of Available Training Mechanisms

In matching potential training needs to available programs, the availability of suitable programs was discussed with many agencies. In order to delineate where the responsibility for such a program might fall within the MEDDAC organization, discussions were held with representatives from Nursing Education and Training, Plans Operations and Training Division, and the Civilian Personnel Office. Nursing Education and Training, under the current organization, offers no staff development type training. The orientation of this office is toward the clinical continuing education needs of the Department of Nursing only. Plans Operations and Training Division concerns itself only with military type training which is required either for MOS qualification or recurring military requirements. The Civilian Personnel Office offers a basic supervisor's course, which is mainly concerned with an orientation to the functions of the CPO. This program has no consumer awareness component, and is limited to supervisors. A three day seminar in office communications

is planned for the post. This seminar will emphasize non-verbal communication, courtesy and telephone procedures. The session is, however, limited to twenty-five participants from the entire installation.

Analysis of other agencies outside of the military community provided several examples of viable programs, but none which could be superimposed in this hospital setting. Most organizations with successful programs felt that whatever program is used must be tailored to the specific, identified training needs of individual sections within the hospital. The program must also be tied to some diagnostic tool so that training is not conducted just for its own sake, but serves a real need.

One of the major civilian hospitals in the Columbia, South Carolina area, begins its emphasis on patient awareness during the employee's orientation. The Hospital Administrator always addresses the weekly Employee Orientation class, emphasising the importance of each employee in establishing a positive impression of the hospital with patients and visitors. This talk helps establish a feeling of pride and self worth in the new employee and illustrates management's commitment to patient awareness. Employees also have the opportunity to attend a hospital sponsored patient awareness workshop. This workshop uses role playing, group work and lectures to assist the employee in identifying and understanding his or her values and attitudes and how they impact on the performance of the job. Then some alternative means of dealing with conflict situations are presented through role playing situations. This program has been so successful in promoting improved patient awareness that the hospital has decided to make it mandatory for all new employees during their first three months of employment. The hospital has also put together several short slide and tape programs for use in inservice training at the department or service level. One of these programs utilizes some exaggerated role playing situations to illustrate the effects of

different approaches to conflict situations. The other program shows the impact of body language, expression, eye contact and touching, in the communication process. This same hospital is developing a staff development program for its new supervisors and managers. This program, now in the planning stage, will provide some basic management skills for new supervisors and will offer more advanced work for higher level managers.[35]

The Veterans Administration hospital system, having come under severe criticism regarding the quality of services rendered to veterans, has embarked on the largest and most ambitious human relations program ever undertaken by any agency of the Federal Government. The program, known as the MAS National Training Program, was developed after nationwide patient attitude surveys indicated the need for improved human relations among the Administrative Staff of Veterans Administration Hospitals. The program, which was reviewed by training specialists, Medical Administration Staff employees, and Management personnel, was given to 17,000 employees of the Veterans Administration's Medical Administration Service. There is to be an annual refresher course for all current employees and mandatory attendance for all new employees during their orientation period. The thirty hour program, which is conducted in two hour blocks, utilizes videocassettes, written exercises, discussions and handouts, to improve organizational and interpersonal skills of employees. Emphasis in the program is on communication and knowledge of the Veterans Administration system, so that employees will be better able to communicate accurate and helpful information to patients.[36]

The Veterans Administration also encourages the development of inservice programs on human relations at the department or service level. These programs utilize both prepared materials and internally generated programs directed at specific problems in the department.

The U.S. Army Health Services Command has recognized the need for

improved human relations in the ambulatory care setting through its Ambulatory Care Models. The Health Services Command approach, rather than providing a canned program, has emphasized the internal development of programs which address specific needs. Ambulatory Care Model Number Six provides several diagnostic tools that the supervisor can use to determine the training needs of the organization. The Model then provides some sources for developing intervention strategies to correct human relations problems. This program is designed to operate at the service or activity level with very specific interventions tailored to specific problems.

Proposed System Alterations

Improved Patient Relations will become possible through the improvement of both patient and employee environments and through the training of employees in patient awareness. These improvements in patient and employee environment will minimize the amount of conflict potential which must be dealt with through the staff training effort. Improvements in the patient environment should be directed toward providing better patient information and improved physical environments in the hospital. Improvements in employee environment will include increased job satisfaction and improved supervisor training. The staff training program will then be designed to mitigate the remaining conflict potential by helping the employee identify his or her feelings and gain an appreciation for the feelings of the patient.

Improvements in the patient environment must begin with better information. This should include more concise, readable publications concerning available services, improved directional signs in the hospital, and a source of verbal directions. The outpatient information booklet should be revised so that all information regarding a particular service is contained on one indexed page. Prior to publication of the booklet, it should be staffed

through major hospital departments and field checked by a random sample of potential patients. Its value will be proven only if the user is able to assemble needed information from the publication.

A critical review should be conducted of signs throughout the facility. Paper signs should be replaced with permanent ones, if the sign is actually required. Other wordy signs which explain detailed systems or policies should be removed, as the detail involved discourages a complete reading by any but the most meticulous visitor. Remaining directional signs should be checked for clarity and to insure that guidance is provided at all major turning points within the facility. The floor selection buttons in patient elevators should be labeled to indicate the floor locations of the main lobby and admitting desk, as many visitors automatically return to the first floor to exit the building (this is confusing because the entrance lobby is on the second floor). Serious consideration should be given to the supplementation of the sign system with a staffed information desk. This service could be provided by part time employees or volunteers who are well versed in hospital policies and the location of services.

Further improvements in patient environment will result by achieving a more relaxed environment in waiting areas. Diversions, in the form of current periodicals and television should be available in all reception areas. Crowding, particularly in the Emergency Room, should be reduced by requiring individuals who accompany patients, to wait in the main lobby area. Temporary partitions in use in the emergency room should be replaced by a more attractive and more easily negotiated barrier. Finally, the ambulance section should be moved to another location. The reduction of personnel in the reception area would add greatly to the professional appearance of the area.

A further indirect improvement in the patient environment would be

achieved through increased accessibility of the Patient Representative, and increased input, by the Patient Representative, into the decision making process of the hospital. Under the present system, the Patient Representative deals directly with staff members to resolve patient problems. General trends are brought to the attention of the Hospital Commander on an informal basis. Though this type of relationship is all important in the advocacy role of the Patient Representative, there are issues which department heads refuse to address in this informal manner. An improved, consistent problem identification and resolution process could be maintained through a Patient Care Committee. This committee, with representation from administration, nursing, major departments and the Patient Representative, would review non-technical patient complaint data compiled by the Patient Representative. Through its discussions, the committee would develop suggestions for corrective action, and follow up on compliance. To facilitate a complete analysis of patient concerns, this committee should have at its disposal periodic patient survey data. This survey should take random samples of patients from all services so that areas of concern not listed in complaint data can be isolated and resolved.

The employee's environment will be improved through a combination of increased job satisfaction and higher quality supervision. Common elements of job satisfaction such as salary, promotion potential and job enrichment are difficult to address in the government sector; but other elements can be altered through more concerned management. One major component of job satisfaction which is under the control of management is the frequent recognition of both the quality and difficulty of the work being done. Most important, however, will be the consistent application of good management techniques to insure that every department adheres to established policies and that communication is maintained among activities. For this reason, Staff Training and

Development will be the linchpin of the employee satisfaction effort.

The staff training program should supplement the Basic Supervisors Series sponsored by the Civilian Personnel Office, with instruction in communication and interpersonal skills. It should utilize both inhouse specialists and guest lecturers to help supervisors understand the stresses acting on employees and provide means by which the supervisor can buffer some of this stress. Periodic discussion groups should be scheduled to allow the exchange of information among supervisors and to foster the resolution of inter-departmental problems.

Lastly, patient awareness programs should be established for all staff members. This program should consist of: new employee orientations, group discussion periods, patient awareness workshops and inservice programs.

New Employee Orientations should be given either weekly or monthly, depending on the number of new employees entering the institution. This orientation should provide a quick overview of the hospital's organization, ploicies and procedures, and should feature a brief appearance by the Hospital Commander. The Commander can use this opportunity to set the tone for personal caring in the hospital operation. He can also help foster pride and self worth among the new employees by recognizing their importance and individual contribution to the accomplishment of the mission. The knowledge of the part played by each employee in the delivery of quality care will help to insure that the best possible impression is put forward, by the employee, in daily contacts with the public. This general orientation should be followed by more specific departmental orientations where, among other things, the peculiar patient awareness needs of that area can be discussed.

Problem identification and resolution should begin with small discussion groups at the department level. These sessions could be chaired by the Patient Representative, with individuals attempting to identify the problems which

effect that area. The patient representative can focus the discussion by compiling patient complaint data for that area and presenting it as a topic for discussion. Once problems are identified and there is agreement that they are real, the group can strive to develop solutions.[37] If the problem is one that involves only that work group, the solution can be implemented and the patient representative can report the results to the Patient Care Committee. If, however, the solution to a problem involves more than one work group, the patient representative can present the proposed solution to the Patient Care Committee for review and possible implementation. Periodically, larger groups should be brought together so that common problems can be analysed, and inter-departmental communication fostered.

Patient Awareness Workshops should be available for all employees in order to provide employees with some tools to assist in improved patient interactions. These workshops should utilize qualified facilitators to put the employee in touch with his or her values and attitudes, and should provide a means of analysing how these attitudes impact on the performance of the job. After "unlocking" the old behavior patterns, the facilitator can offer some alternative means for dealing with various conflict situations. It may be too much to hope that these interventions will have any lasting effect, but the awareness generated on the part of the employee may cause some surface moderation of behavior.

Inservice sessions should be able to stand alone as one or two hour sessions, or act as supplements for the workshops. The majority of these programs should be generated within the department and be specific to its identified needs. There should, however, be some general subjects programs for use by all departments, as needed. These programs should emphasize such topics as non-verbal communication, eye contact and telephone courtesy.

The Patient Care Committee, through the Patient Representative, should monitor the inservice part of the program, to insure that every department responds to problem trends with some form of inservice training.

CONCLUSION

In this study, patient complaint data was used to identify and isolate problems which might be resolved through staff training in patient awareness. This analysis identified the shortage of provider resources and the technical quality of care as the most common sources of dissatisfaction. There were, however, a significant number of complaints regarding staff rudeness, long waits and poor information provided by the staff. These findings were reinforced by findings of outpatient surveys and direct observation of patient care areas.

Many patient awareness programs in use in other hospitals were analysed to determine what programs might be fashioned to address the specific needs of this hospital. Though other hospitals had successful programs, the training directors of those institutions recognized that a successful program must be tailored to the specific needs of the individual work units within the hospital.

Given the types of problems effecting patient awareness at this hospital, a three phased program was designed which would concentrate action in three areas: improvement of patient environment, improvement of employee environment and patient awareness training. The first two elements of the program are necessary to reduce the amount of conflict potential which must be dealt with through behavior modification. Improvements in the patient environment include the provision of better information and a more attractive physical environment within the facility. Improvements in employee environment include increased job satisfaction and higher quality supervision. This improved supervision would be achieved through a supervisor development program sponsored by the hospital. Patient awareness training would, itself, be divided into four

components. Discussion groups would be established to identify and make suggestions for resolution of problems effecting that area. Patient Awareness Workshops would be used to develop those skills which will allow the employee to cope more effectively with conflict; while inservice training sessions will both address specific problems effecting work groups and provide tools for dealing with given situations.

The entire patient awareness effort will be tied together through a Patient Care Committee. This committee will work with the Patient Representative in reviewing and analysing non-technical patient complaints to develop and follow up on corrective actions.

These actions, in combination, will assist greatly in improving patient relations at Moncrief Army Hospital.

FOOTNOTES

[1]Joseph L. Bloch and Bernard Hankin, "Hospital Responds To Community Protest," Hospitals, (48), September 1974, p. 54.

[2]Robert M. Cunningham Jr., "If We Don't Care, They Won't," Hospitals, (52) 20, October 16, 1978, p. 67.

[3]Bloch, p. 54.

[4]Ibid., p. 53

[5]Cunningham, p. 68

[6]Ibid., p. 67.

[7]Bloch, p. 53.

[8]Christina Maslach, "Burned-Out," Human Behavior, September 1976, p. 17.

[9]Elizabeth Hughes, "Helping Staff To Manage Conflict Well," Hospital Progress, July 1979, p. 68.

[10]"Employee Attitudes Have Significant Impact On Patient Care, Says Levinson," Cross-Reference On Human Resources Management, 8 (1), January-February 1978, p. 1.

[11]Cunningham, p. 68.

[12]Gretchen V. Fleming, "Using Consumer Evaluations of Health Care," Hospital Progress, August 1979, p. 57.

[13]Cunningham, p. 67.

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[15]Rex H. Warland, Robert O. Herrmann and Jane Willits, "Dissatisfied Consumers: Who Gets Upset and Who Takes Action," The Journal of Consumer Affairs, Winter 1975, p. 160.

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